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CHAIR

STATE OF MARYLAND

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# MARYLAND HEALTH CARE COMMISSION

**Thursday, November 20, 2008**
**Minutes**

Chair Moon called the meeting to order at 1:05 p.m.

Commissioners present: Conway, Falcone, Jefferson, Krumm, McLean, Moore, Ontaneda-Bernales, Petty, Pollak, Todd, and Worthington.

## ITEM 1.

**Approval of the Minutes**

Commissioner Todd made a motion to approve the minutes of the October 16, 2008 meeting of the Commission, which was seconded by Commissioner Petty, and unanimously approved.

## ITEM 2.

**Update of Activities**

Rex Cowdry, M.D., Executive Director, announced that, due to the length of next month's agenda, the December public meeting will begin at 12:30 p.m.

David Sharp, Director for the Center for Health Information Technology presented one additional item to the written update. He announced the addition of Kimberly Clayton as an Advanced Health Policy Analyst in the Center for Health Information Technology, HIE Division working for Kathy Frances, who is the Division Chief. Ms. Clayton most recently served as Director of Health Services at Broadmead Retirement Community. She brings 20 years of executive management experience in nursing homes and retirement communities. Ms. Clayton is very familiar with the challenges of health IT adoption in long term care and will be instrumental in working with this stakeholder group to promote health IT adoption. She holds a BA in Psychology.

**ITEM 3.**

**ACTION: COMAR 10.25.07– Certification of Electronic Health Networks and Medical Claims Clearinghouses**

Kathleen Francis, Chief, Health Information Exchange, presented regulations, COMAR 10.25.07 – Certification of Electronic Health Networks and Medical Claims Clearinghouses, for final action. Ms. Francis said the regulations will enable the Commission to consider comparable industry network accreditation as part of the MHCC certification review process. She said the proposed permanent regulations, adopted by the Commission at its August 5, 2008 meeting, had been published in the *Maryland Register* and that no comments were received during the 30-day formal public comment period. After discussion, Commissioner Falcone made a motion to adopt the regulations as final, which was seconded by Commissioner Jefferson, and unanimously approved.

**ACTION: COMAR 10.25.07 – Certification of Electronic Health Networks and Medical Claims Clearinghouses – is ADOPTED as final regulations.**

**ITEM 4.**

**ACTION: Small Group Market Coverage Policies**

- Dependents up to age 25

Janet Ennis, Chief, Small Group Market, presented the staff recommendation on whether to adopt the provision for covering child dependents up to age 25 in the small group market. Ms. Ennis noted that this coverage is now required in the individual and fully-insured large group markets, and said that the Commission has full discretion on whether to adopt a similar requirement for the small group market. Ms. Ennis also noted that, in November 2007, the Commission considered adopting this coverage provision in the small group market but elected to maintain the status quo of allowing carriers to offer small employers a rider covering child dependents up to age 25, and employers to purchase such a rider. Ms. Ennis said Chairman Middleton, Delegate Mizuer, and the Maryland Citizens Health Initiative asked the Commission to study this coverage option as well. The Commission's actuarial consultant, Mercer {GIVE COMPLETE NAME, if there's more}, estimated that, if dependent coverage was provided up to age 25, the cost impact on the overall CSHBP premium would be an increase of between 0.5% and 1.1%. Ms. Ennis said that staff conducted a recent survey of small group carriers and found that only one carrier extended this coverage in its small group market policies and none of the small group carriers currently offer it as a rider. Staff recommended that the Commission extend the coverage option that would require carriers to provide coverage of child dependents up to age 25 in the small group market. Ms. Ennis stated that the modest additional cost of extending coverage to these young adults provides an effective way to assure continued participation in the insurance pool during the transition and an effective way to reduce the number of uninsured individuals who may generate uncompensated care due to an unforeseen event. After some discussion, Commissioner Falcone made a motion to accept the staff recommendation, which was seconded by Commissioner McLean, and unanimously approved.

**ACTION: Requiring carriers to provide coverage of child dependents up to age 25 in the small group market, is hereby APPROVED.**

- Domestic Partners

Bruce Kozlowski, Director of the Center for Health Care Financing and Policy, presented the staff recommendation on whether to adopt the option of covering domestic partners and their dependent children in the small group market. Mr. Kozlowski noted that this coverage is now required in the individual and fully-insured large group markets and said that the Commission has full discretion on whether to adopt a similar requirement in the small group market or maintain the status quo, which permits carriers to offer small employers a rider to cover these individuals. He said the Commission cannot adopt the provisions of HB 1057 in the small group market, since the bill mandates the availability of a rider, which is not permitted in the small group market. He explained that the Commission has the authority to define the Comprehensive Standard Health Benefit Plan (CSHBP), but Commission counsel concluded that the Commission does not have the authority to mandate that a particular rider be offered under the CSHBP. Mr. Kozlowski stated that three major carriers already offer domestic partner coverage as an option to small employers, charging the same premium for domestic partner coverage that is charged for spousal coverage. He said that, in practice, maintaining the status quo will result in employer options in the small group market that are similar to those mandated in the large group market under HB 1057. Staff recommended that the Commission continue with current small group policy, which allows carriers to offer coverage to domestic partners and their dependent children as a rider in the small group market. After discussion, Commissioner Worthington made a motion to accept the staff recommendation, which was seconded by Commissioner Moore, and approved with one dissenting vote.

**ACTION: Continuing with current policy in the small group market, which permits carriers to offer coverage to domestic partners and their dependent children as a rider, is hereby APPROVED.**

**ITEM 5.**

**PRESENTATION**: Assessing Differences in Potentially Avoidable Hospitalizations Among Medicare Beneficiaries in Maryland - 2006

Dr. Tim Lake, Senior Researcher, and Ms. So O'Neill, Researcher, of Mathematica Policy Research Institute briefed the Commission on a study to expand the understanding of health care disparities in the State. Dr. Lake said that the goals of the study were to assess racial, socioeconomic, and geographic differences in hospitalization rates for ambulatory care sensitive conditions (ACSC); identify differences in rates that may indicate disparities in quality of care; and estimate potential cost-savings from reductions in the ACSC hospitalization rates. He said the ACSC measures used the Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators for eight conditions. Dr. Lake also discussed, in detail, the study parameters. Ms. O'Neill briefed the Commission on the overall findings of the study. She said that the performance of outpatient care systems can include both quality of care delivered by individual providers and system-level factors that affect patient access to care. High rates of ACSC-related hospitalizations may indicate problems with the quality of care in outpatient health care systems. Differences in rates between different groups could arise from inequities in the quality of care, although differences in disease burden and other factors are also likely to play a role. Ms. O'Neill reviewed the ACSC hospitalization rates and their associated hospital costs. She provided a summary of potential cost savings through reducing the hospitalization rates, indicating that annual savings are greatest for conditions that occur most frequently with the highest median costs. She discussed the racial differences in ACSC hospital rates and prevalence of disease, noting that racial differences in rates persist after controlling for differences in prevalence and also persist across income levels. She also noted that lowering African American beneficiaries' rates to those of white beneficiaries could achieve over 40% of the potential ACSC cost savings. In conclusion, Ms. O'Neill said that racial differences in ACSC

hospitalization rates cannot be fully explained by underlying prevalence, demographic, or socioeconomic differences. She said that variation in the quality of outpatient systems is likely a key factor in explaining differences; while other factors may also account for some of these differences, they do not diminish the role that the outpatient system plays. Dr. Lake discussed possible opportunities for improvement in the outpatient health care system including: (1) outreach to policymakers, health plans, and providers with the results of the study; (2) development of community initiatives to address areas with high ACSC hospitalization rates; and, (3) development of a process to continually track ACSC hospitalization rates.

**ITEM 6.**

**PRESENTATION:** Maryland Patient Safety Center, Inc.

Dr. William Minogue, Executive Director, Maryland Patient Safety Center, Inc., and Dr. Christian Jensen, President and CEO of Delmarva Foundation for Medical Care, briefed the Commission on the activities the Center. Dr. Minogue said that, in 2004, the MHCC selected the Maryland Patient Safety Cent, Inc. to develop and implement strategies to improve the safety of patient care in Maryland. The Maryland Patient Safety Center is comprised of LogicQual Research Institute (a subsidiary of the Maryland Hospital Association) and the Delmarva Foundation, two organizations that have been leaders in patient safety and quality initiatives. Dr. Minogue said that key strategies of offering a comprehensive programming, including education and training, collaborative programs, adverse event reporting, research and special projects, combined with medical review committee status for information confidentially, have provided Maryland healthcare providers with a safe haven for improvement and learning. He highlighted some of the Center's achievements, including:

- 2005 John M. Eisenberg Patient Safety and Quality Award for national/regional innovation in patient safety;
- Participation by over 8,400 providers in educational programs, 85% of hospitals in collaborative programs, and 55% of hospitals in the Adverse Event Reporting System;
- Improved outcomes and processes, including reductions in ventilator associated pneumonia and catheter-related blood stream infections during the Intensive Care Unit Collaborative, resulting in an estimated 140 lives saved and $40,775,070 in avoided costs; improved Emergency Department (ED) flow and timing processes reported during the ED Collaborative; and other improvements related to methicillin-resistant Staphylococcus aureus (MRSA), perinatal care, and handoffs and transitions;
- Creation of an Adverse Event Reporting System that explores patterns and trends related to patient safety events and "near misses" that occur in healthcare facilities;
- Development of a safety center model that other states seek to learn from and emulate;
- Increased funding support from a diverse set of sources, including hospitals, MHA, Delmarva Foundation, the Maryland Department of Health and Mental Hygiene, the Health Services Cost Review Commission, CareFirst BlueCross BlueShield, and others; and
- Various publications and communications, highlighting program participants and the Center's successes.

In conclusion, Dr. Minogue asked the Commission to redesignate the Maryland Patient Safety Center, Inc. as Maryland's patient safety center for an additional five years beginning January 2009. He indicated that the Center accepts and will comply with the "specific performance requirements" outlined in the Commission's *Public Notice and Request for Expressions of Interest: Designation of the Patient Safety Center for the State of Maryland.*

**ITEM 7.**

**ACTION:** Redesignation of Maryland's patient safety center

Dr. Rex Cowdry, Executive Director, recommended that the Commission redesignate the Maryland Patient Safety Center, Inc. (MPSC) as the State's patient safety organization for an additional five years, beginning January 1, 2009 through December 31, 2014. Dr. Cowdry said the Commission posted a notice requesting comments on the performance of the current designee and requests for expressions of interest from others that were interested in being designated as the safety center for the coming five-year period. He said that the MPSC was the only organization requesting designation. Dr. Cowdry said that the Center has built a remarkable collaborative team to improve health care quality and prevent medical errors and recommended that the Commission approve the redesignation. After discussion, Commissioner Krumm made a motion to approve the staff recommendation, which was seconded by Commissioner Ontaneda-Bernales, and unanimously approved.

**ACTION: Redesignating the Maryland Patient Safety Center for an additional five years, is hereby APPROVED.**

**ITEM 8.**

**ADJOURNMENT**

There being no further business, the meeting was adjourned at 3:15 p.m., upon motion of Commissioner Pollak, which was seconded by Commissioner Todd, and unanimously approved.